

PRIMARY CARE PHYSICIAN APPLICATION

COLORADO DEPARTMENT OF HEALTH CARE POLICY & FINANCING

Please complete the entire application and sign on page 3.

Mail the completed Application and all supporting documentation to:

Fiscal Agent for the Medical Assistance Program
ACS
Provider Enrollment
Post Office Box 1100

Denver, Colorado 80201-0090

For Official Use Only			
Date Application Received:	Application Complete:	☐ Yes	☐ No
	_		
Application pending additional information needed:			
Reviewed by:			
Medical Assistance Program Fiscal Agent			

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PCP ENROLLMENT

Are you a first time PCP applicant?				
Please indicate the provider number to which group #):	Medical Assistance Program payment should be made (i.e., individual or			
☐ Individual #:	or			
	Inglish, including American Sign Language? 🔲 Yes 🔲 No			
If yes, please list:				
	IAL PHYSICIAN BACKGROUND INFORMATION			
Name: (Last, First, MI)	☐ MD ☐ DO Date of Birth: / /			
Colorado Board of Medical Examiners Lice	ense Number: Expiration Date:/ /			
DEA Number:				
CLIA Number:				
	Expiration Date: / /			
Medical Assistance Program Individual Provider Number: Social Security #:				
Medicare Certification: Yes N				
Board Certification(s): Yes N				
1				
2.				
3.				
Medical Malpractice Insurance Carrier:	(Must comply with current Federal and State regulations)			
SECTION	ON II: PRACTICE INFORMATION			
DBA Name:				
(Indicate Doing Business As (DBA) Group Practice name, if different from name)				
Group #:				
,,	☐ Individual ☐ Group			
	ic Federally Qualified Health Center Indian Health Clinic			
Primary Office Address:				
	Counties served:			
	Fax:			
	Office Hours:			
Second Office Address: Zin+4 Code: County:	City: City:			
	Fax:			
E-mail:	Office Hours: cal Assistance Program clients? % (Best Estimate)			
Are you currently willing to accept addition				
Assistance Program clients?	Yes No If yes, how many?			
Professional Staffing:				
Residents: Yes No If yes, how many?				
Non-Physician Professionals: Yes No If yes, please indicate the number of each of the following:				
Nurse Practitioners:	Physician Assistants:			
Clinical Nurse Specialists: Certified Nurse Midwives:				

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SECTION III: ACCREDITED AFFILIATIONS

This section is used by the Department of Health Care Policy and Financing for credentialing verification.

Α. Ι	Hospital affiliations
1.	Name of Hospital:
	City: County:
2.	Name of Hospital:
	City: County:
]	If no privileges, please describe your hospital admission protocol:
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_	
В.	List all Managed Care Organizations affiliations:
1.	
2.	
3.	
4.	
1.	O NV - D O D O O
	SECTION IV: PRIMARY CARE PHYSICIAN CASE MANAGEMENT CERTIFICATION
I,	, hereby certify that:
1.	The preceding Primary Care Physician information is accurate and completely represents my current certification and practice.
2.	I am able to perform the essential duties of the Primary Care Physician as stated in the PCP contract.
3.	I am not currently using or dependent on any illegal or addictive substances.
	SECTION V: TERMS OF APPLICATION
	e following <i>required information</i> must be attached to this application. Failure to provide this information makes application null and void.
1.	Five-year claims liability history or statement that there is no claims liability history.
2.	Copy of your curriculum vitae for the last five calendar years. Please include medical education, training, work history and describe any gaps
Coı	s Application supplements your current Colorado Medical Assistance Program Primary Care Physicians ntract and Medical Assistance Program Provider Enrollment Application and will be enforced in conjunction rein. A breach of any is a breach of all.
I,	(Print name and title)
cer acc	tify that all preceding information is correct and complete. I acknowledge that failure to provide true and urate information is grounds for termination from the Primary Care Physician Program and possible overies of payment with penalties.
NC resi	OTICE TO APPLICANT: Your submission of this application constitutes an offer. Acceptance of this offer ults in a binding agreement effective upon approval of your application. The terms of the agreement include ar application, the Primary Care Physician Contract and the Medical Assistance Program Provider Enrollment plication.
Fin	a physician in the Primary Care Physician Program, you agree that the Department of Health Care Policy and ancing may execute this agreement by electronic signature, which will constitute an original of this plication and be enforceable as if manually signed by the State.
	Signature Date

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